

MY COPD ACTION PLAN

Actions to take if my symptoms get worse
Bring this plan with you every time you visit your doctor

General Information

Name:	Date of Birth:
Emergency Contact:	Phone Number:
Physician/Healthcare Provider Name:	Phone Number:
Physician Signature:	Date:

Inhaled Daily Medicines

	Name of Medicine	How Much to Take	When to Take It
Quick Relief			
Long-Acting			
Inhaled Steroid			
Combination			
Nebulizer			

Green Zone: I am doing well today

Actions

- Usual activity and exercise level
- Usual amounts of cough and phlegm/mucus
- Sleep well at night
- Appetite is good

- Take daily medicines
- Use oxygen as prescribed
- Continue regular exercise/diet plan
- At all times avoid cigarette smoke, inhaled irritants

Yellow Zone: I am having a bad day or a COPD flare

Actions

- More breathless than usual
- I have less energy for my daily activities
- Increased or thicker phlegm/mucus
- Change in color of phlegm/mucus
- Using quick relief inhaler/nebulizer more often
- Swelling of ankles more than usual
- More coughing than usual
- I feel like I have a "chest cold"
- Poor sleep and my symptoms woke me up
- My appetite is not good
- My medicine is not helping

- Continue daily medications
- Use quick relief inhaler every _____ hours
- Start Prednisone: _____
- Start Antibiotic: _____
- Use oxygen as prescribed
- Get plenty of rest
- Use pursed lip breathing
- At all times avoid cigarette smoke, inhaled irritants
- Call provider if symptoms don't improve

Red Zone: I need urgent medical care

Actions

- Severe shortness of breath even at rest
- Not able to do any activity because of breathing
- Not able to sleep because of breathing
- Fever or shaking chills
- Feeling confused or very drowsy
- Chest pains
- Coughing up blood

- **Call 911 or have someone take you to emergency room**
- **Increase oxygen to:** _____
- **Take Prednisone:** _____

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Lung Function Measurements		
Weight: _____ lbs Date:	FEV1: ____ L ____% predicted Date:	Oxygen Saturation: _____% Date:

General Lung Health Care		
Flu vaccine	Date:	Next Flu Vaccine Due:
Pneumonia vaccine	Date:	Next Pneumonia Vaccine Due:
Smoking status	<input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	Quit Smoking Plan <input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise plan <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Walking <input type="checkbox"/> Other _____ ____ min/day _____ days/week	Pulmonary Rehabilitation <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Goal Weight:	

Inhaled Daily Medicines			
	Name of Medicine	How Much to Take	When to Take It
Quick Relief			
Long-Acting			
Inhaled Steroid			
Combination			
Nebulizer			

Other Medicines for COPD			
	Name of Medicine	How Much to Take	When to Take It
Quit Smoking Aid			
Other			

Oxygen		
Resting:	Increased Activity:	Sleeping:

Advanced Care and Planning Options				
<input type="checkbox"/> Lung Transplant	<input type="checkbox"/> Lung Reduction	<input type="checkbox"/> Transtracheal Oxygen	<input type="checkbox"/> Night-time Ventilator	<input type="checkbox"/> Advanced Directives

Other Health Conditions			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> GERD/Acid Reflux
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Kidney/Prostate
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other:		